COUNTY OF SAN DIEGO MENTAL HEALTH SYSTEM

EXECUTIVE SUMMARY

CULTURAL COMPETENCE PLAN 2010

COUNTY OF SAN DIEGO MENTAL HEALTH SERVICES

Version 3, 3/18/11

PROGRESS TOWARD CULTURAL COMPETENCE
CULTURAL COMPETENCE PLAN 2010
EXECUTIVE SUMMARY

The County of San Diego has long had a commitment to cultural competence. Sharing a border with Mexico, San Diego has one of the highest immigration rates of all California counties. The need to provide physical and mental health services to persons from many diverse cultures has been acknowledged through all parts of the County's Health and Human Services Agency. San Diego County Behavioral Health Services maintains policies, procedures, cultural competence clinical practice standards, etc. which reflect steps taken to recognize and value racial, ethnic, and cultural diversity. With the advent of Mental Health Services Act funding, the mental health system was able to reach out to diverse cultural groups and tailor new services to the needs of unserved and underserved populations. In planning for these new services the following steps were taken:

- An extensive effort was made to include stakeholders from identified racial, ethnic, cultural and linguistic communities in the planning process. Clients/client family members and other stakeholders were included in ongoing planning councils and committees.

- To be best able to plan for services, San Diego County Mental Health Services has found it more useful and reflective of the County's population to consider the combined needs of the Medi-Cal and indigent populations, since fully 45% of the adult mental health population and 15% of the children's population are uninsured.

- Two major reports were created to foster data-driven decision making. The SDCMHS Gap Analysis and report on "Progress Toward Addressing Disparities: A Five-Year Comparison FY 2001-02 to FY 2006-07" have served as the basis for planning service direction and expansion for MHSA Community Services and Support, Prevention and Early Intervention, Workforce Education and Training, and Innovations programming.

- Program expansion included efforts to strengthen existing community based organizations to broaden access to care.

DISPARITIES FOUND

Racial/Ethnic Disparities

The Gap Analysis and Progress Toward Addressing Disparities indicated the following race/ethnicity service disparities:

Latinos

The gap analysis data pointed to a clear need to increase access to care for Latino children, TAY, adults, and older adults who live in poverty. Latino females, as compared to males, tend to be under-represented in both children and TAY age groups. There is no gender gap among adult Latinos. According to the data, older adult Latino males are under-represented. Latino children who are fully served in the Children's System of Care/Wraparound Services program represent approximately 27% of all fully served youth. Latino fully served adults and older adults in the REACH program represent only 12% of all fully served population of the REACH program. Thirty-one percent of Hispanic adult clients identified Spanish as their preferred language which may contribute to difficulty in engaging adult clients—one-third left after fewer than five visits to outpatient services.

Asian/Pacific Islanders

The Asian/Pacific Islander population is under-represented in the public mental health system, comprising 8% of the target population and only 5% of current mental health clients. This population is complex, drawn from numerous countries, and comprised of many linguistically and ethnically diverse groups. The Asian/Pacific Islander umbrella group includes Amerasian, Cambodian, Chinese, Filipino, Hawaiian Native, Hmong, Japanese, Korean, Laotian, Pacific Islander, and Vietnamese. Forty-one percent identified an Asian language as their preferred language. Children in this group had the lowest engagement rates, with 16% having only one visit to mental health services. The need for easily available interpreting services for parents/family may be higher for this group to be able to engage children. Clients are more likely to be female.

African Americans

The African-American general population is expected to stay relatively constant at 5-6%, yet they are over represented in acute inpatient care, in the juvenile forensic system and in adult jail mental health services. They are also more likely to receive a diagnosis of schizophrenia and are more likely to be male.

Native Americans

While there may not be a substantial difference between Native Americans served and the county's Native American population, San Diego County is home to 17 reservations, composed of numerous tribal groups. Mental health clients are more apt to be female. The SDMHS gap analysis noted that Native American children compose 1% of the children's mental health system, yet have disproportional rates of contact with other systems:

- They represent 1.6% of the mental health clients concurrently receiving Child Welfare Services;
- 3.2% are concurrently receiving services in Alcohol & Drug Services; and
- 0.2% of the children concurrently open to Juvenile Forensic Services.

These data on involvement in other systems may reflect inappropriately served populations that may benefit from mental health services.

Age Group Disparities

- Transitional aged youth (ages 18-24) who are aging out of the children's mental health system and not connecting with the adult system. Transition Age Youth had the lowest access rates among age groups and their access to services declined slightly over time.
    - 31% had three or fewer visits to outpatient services.
    - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to outpatient services.
- Older adults (ages 60+) who were dealing with transportation barriers to service as well as cultural barriers.
- Very young children (ages 0-5) **,** especially for early intervention and prevention efforts.
- Outside factors affect children's usage of mental health services
    - 20% of children receiving mental health services were also involved with Child Welfare Services and 36% were receiving Special Education services.
    - 24% of children ages 12-17 used juvenile forensic mental health services only, while 18% of CMHS clients were also open to the Probation System.

Special Cultural Group Disparities

Veterans

There are a substantial number of veterans who have returned from service in overseas conflicts and are seriously mentally ill, in need of comprehensive mental health services. The MHSA Community Services and Supports programs will include, throughout its service array, all veterans who meet the MHSA and DMH guidelines.

PEI Special Situational Populations

PEI Services will be targeted at the following groups who are experiencing difficulties as a result of special circumstances:

- African refugees
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of experiencing juvenile justice involvement

Workforce Disparities Compounding Barriers to Culturally Competent Services

The Workforce Education and Training Plan notes that the staffing disparities listed below add barriers to the expansion of programming to unserved and underserved populations:

- Unlicensed Direct Staff positions remained vacant primarily as a result of both non-competitive salaries and the unique qualifications needed for these positions; whereas Licensed Direct Staff positions were difficult to fill due to noncompetitive salaries and requirements for bilingual staff, primarily Spanish;
- Qualified clinical supervisor positions were identified as hard-to-fill, especially professionals with LCSW or MFT licensure;
- Hospitals and clinics are struggling from the overall shortage of nurses available in the county;

- Several positions have been vacant for over a year, particularly in rural areas or positions requiring licensed bilingual capability;
- Intense competition exists in the community for bilingual professionals and bilingual clinical positions;
- Latinos and African Americans are under-represented in mental health staffing;
- There is a need for positions designated for individuals with consumer and/or family member experience;
- There is a need for staff language proficiency in the following languages: Spanish, Tagalog, Vietnamese, Arabic, Russian, Cambodian, ASL, Lao, Somali and Swahili.

A long-standing shortage of psychiatrists with linguistic specialties and child psychiatrists have also compounded the problem of providing culturally appropriate services.

NEW MHSA PROGRAMMING ADDED TO ADDRESS DISPARITIES

Community Services and Support (CSS) Plan

Three basic types of services were established to meet the needs of unserved and underserved:

1) Outreach and education to acquaint underserved or unserved groups about mental health problems and services/

2) System Development programs to add targeted services to meet the needs of cultural, racial, and ethnic groups;

3) Full Service Partnerships for persons with severe, persistent mental health problems to provide a full spectrum of services ranging from housing, therapy and medication, to whatever it takes to support them in the community.

A total of 40 programs were started between 2006 and 2009. The following strategies guided the establishment of CSS programs:

- Conduct outreach to engage and increase access to care for Latinos and Asian/Pacific Islanders, African Americans, and Native Americans in the mental health system.
- Increase penetration and rates of client retention for underserved and unserved clients in age groups and racial/ethnic groups and for females.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Provide culturally competent mental health services in all MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.
- Include training on working with interpreters, the deaf and hard of hearing, victims of trauma, and gender and sexual orientations in cultural competence training.
- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining and retraining culturally competent staff.

- Address disparities in services for females in all age groups by requiring MHSA programs to ensure females are assessed for mental illness.
- Increase access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental health services in community clinics.
- Establish relationships with tribal communities for as many of the 17 Native American tribes as possible who have reservations in San Diego County.
- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities.

See the Cultural Competence Plan Appendix for a description of the forty programs, their target populations, services offered and program goals.

Prevention and Early Intervention (PEI) Plan

Through the PEI Work Plan, 30 programs were established from 2008-2010. The PEI Work Plan followed the strategies below in developing programming with the goal of reducing service disparities among targeted populations.

- Provide education and outreach campaigns to reduce stigma and discrimination and to aid in suicide prevention for all age groups, race/ethnicities, persons with co-occurring substance abuse disorders, and caregivers.
- Assist in maintaining a safe home and a community safety net for children and in reducing the effects of trauma exposure (including gang experience).
- Promote healthy, effective parenting styles, connecting children with necessary health and other related service, to prevent re-traumatizing children and families already exposed to domestic and/or community violence.
- Increase Native American community involvement and education through services designed and delivered by Native American community members.
- Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children and help reduce their behavioral/emotional problems.
- Reduce the potential negative outcomes associated with mental health issues in the early stages of mental illness.
- Increase access to care for older adults from minority populations.
- Educate caregivers and primary care service providers to increase awareness and understanding of the older adult concerns and create a wellness focus.
- Support caregivers of clients with Alzheimer's, to reduce incidence of caregiver mental health problems.
- Provide outreach and outreach services to the Veterans community to improve their knowledge of and access to mental health services.
- Provide prevention services for clients in rural community clinics to help them address behavioral health issues, addiction, and severe mental illness at an early stage.
- Support persons being treated for substance abuse in dealing with mental health issues through providing integrated services.

See the Cultural Competence Plan Appendix for a description of the PEI programs, their target populations, services offered and program goals.

WORKFORCE EDUCATION AND TRAINING (WET) Plan

In the WET Plan, the strategies, outlined below were adopted to reduce the workforce disparities, discussed previously, so that the County could more effectively provide services for ethnic/racial and cultural populations:

- Address shortages in bilingual staff – Spanish, Vietnamese, Arabic, Tagalog, Russian, Cambodian, ASL, Lao, Somali, and Swahili.
- Implement trainings/educational opportunities to build staff to fill unique qualifications for hard to fill jobs and for clinical supervision.
- Create incentives to encourage nurses, child psychiatrists, etc. to enter public mental health employment and take hard-to-fill positions.
- Increase the numbers of Latino and African American staff.
- Create positions and a career ladder for mental health consumers and/or family members.

Nine programs were begun to implement these strategies, ranging from providing training in core competencies for current staff, to developing career pathways, residency and internship programs, and financial incentive programs. See the Cultural Competence Plan for a fuller description of the nine programs.

MONITORING AND OVERSIGHT TO HELP INSURE THE EFFECTIVENESS OF SERVICES

In order to monitor and measure the effectiveness of MHSA programming in reducing disparities, the SDCMHS updated the following Quality Improvement Plan for FY 10-11:

Quality Improvement Strategies for Addressing Disparities

The Quality Improvement Plan for addressing cultural disparities in San Diego County involves the following activities:

1) Evaluating root causes of disparities in San Diego
2) Assessing effectiveness of current strategies and interventions- as part of Cultural Competence Plan when State gives counties guidelines- on hold
3) Implementing stigma and discrimination educational campaign through MHSA funding
4) Evaluating cultural sensitivity of providers and services-
    a. Facilitate the implementation of the CMCBS to evaluate staff
    b. Implement the Culturally Competent Program Annual Self-Evaluation (CC-PAS) for new and re-procured programs
5) Improving quality of care by working with ethnically diverse groups
    a. Complete and distribute Cultural Competence Handbook- QI- Dec 2010
    b. Identify Culturally Competent EBP, best practices, proven practices- Policy and Practice Committee- will identify 2 new practices by – Dec 2011
    c. Work with Clinical Standards Committee to ensure interventions are culturally appropriate.

d. Study results of outcome measure based on age/racial/ethnic groups- Update Disparities for FY 09-10; data available for comparisons in Jan 2011. (Report will be available in Spring 2011.)
e. Identify community groups that represent age/racial/ethnic/cultural diversity and do focus groups with them to identify areas for improvement- not started yet

The Cultural Competence Resource Team (CCRT)—an advisory board representing an array of stakeholders in the mental health community with a special interest in cultural diversity and the remediation of service disparities is participating in the development and monitoring of MHSA programming. The CCRT and its subcommittees, under the guidance of the Ethnic Services Manager, makes recommendations to Mental Health Administration and the Mental Health Director about issues concerning service disparities and cultural competency development. Accordingly, the CCRT Training and Education Subcommittee has drawn up a list of recommendations for cultural competency courses, requirements, and objectives:

Cultural Competence Resource Team
Training and Education Subcommittee
Recommendations for Cultural Competency Courses Requirements & Objectives
(culture-specific courses)

In cultural competency courses, classes shall address the following:

- Some demographics of the country of origin, which may include maps, its location, population makeup, etc.;
- Discussion of language need, especially if high percentage are monolingual in their native language
- A brief history of the population, which may include migration/integration to and within the United States, the unique impact of migration on the population
- Discussion of any historical trauma, if applicable, such as war trauma, migration trauma, etc.
- Overview of the culture with some of these possible topics: values, sociological history, family structure, customs, perceptions of assistance or help, support systems, spirituality, health approaches, complementary healing approaches, cultural resilience, and language
- Access Issues and/or disparities: community support systems and resources; likelihood of group accessing resources
- Perspective on what causes mental illness and perspective on accessing mental health services
- Discussion of culture-bound mental health syndromes, if applicable
- When applicable to population, overview of unique patterns of acculturation
- Identify any specific generational trends with social/emotional/behavioral/mental health challenges, i.e. children, adolescents, TAY, Adults, Older Adults
- If applicable, discuss common health conditions and challenges, i.e. depression, diabetes, substance abuse, problem gambling, etc.

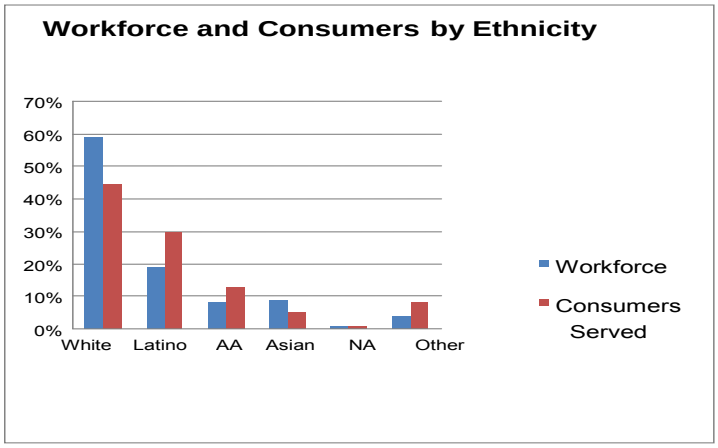
- If applicable the training can also include a quick reference guide with greeting words in the foreign language
- Cover the effects of inter- and intra- cultural racism, stereotypes and myths

If elements listed above are met by the end of the training session, participants should be able to:

- Recognize the need to assess individuals and families based upon a psycho/social/ cultural/political/spiritual perspective.
- Recognize the need to understand cultural differences when working with clients/customers
- Articulate client/customer needs that are culturally appropriate
- Identify and utilize community resources on behalf of the client
- Provide services with understanding of cultural differences
- Advocate to reduce racism, stereotypes and myths

CURRENT CULTURALLY COMPETENT TRAINING ACTIVITIES PROVIDED

With a current workforce of approximately 2,500 persons working in hundreds of programs, the SDCMHS and its contractors have a major task on their hands to ensure the training in cultural awareness and sensitivity of all staff who work directly with clients. A comparison of the current workforce and mental health system consumers indicates that ethnic/racial groups are under-represented in the workforce.



To develop the cultural awareness and sensitivity of the workforce, the SDCMHS requires that contractors have all staff dealing directly with clients receive four hours of cultural competence training each year. These trainings have been conducted by a broad variety of organizations, but not all provider staff have access to an equal array of programs. To help address the variance in training opportunities, the SDCMHS is providing a 4-prong approach to expanding training for existing staff to enhance their level of cultural competence:

1. Training on cultural specialties will continue to be provided through the County Knowledge Center for County employees at no cost and a small number of providers on a fee basis.
2. Contracted trainings through the Behavioral Health Education and Training Academy (BHETA) are offered free of charge to County and contract BHS staff. Both classroom and some on-line trainings are offered. Expansion of on-line trainings is planned.

3. Cultural Competence Academy Training—a 32-40 hour intensive training program, offered once or twice yearly, on cultural awareness, knowledge, and specific skills development. New contractors and contractors winning a re-procurement will be required to send a portion of staff. Providers with 75% of staff attending the Academy will be able to achieve a certification as a Culturally Competent and Proficient Program.
4. WET Workforce Building Activities includes specialized training modules, creating career pathways, providing financial incentives, and providing fellowships/internships.

OTHER CURRENT APPROACHES TO EXPANDING LANGUAGE CAPACITY

- The SDCMHS spends over a million dollars annually to make interpreter services available throughout the outpatient system at no cost to a client or provide help to alleviate the demand for bi-lingual staff temporarily.
- Culturally Competent Clinical Practice Standards mandate that racial/ethnic and cultural factors are integrated into clinical interviews, assessment tools, assessment, medication considerations, etc. Services are to be provided in the client's preferred language. Key points of contact are mandated to have staff or interpretation services available.
- Training for staff on how to best utilize interpreters is being provided.
- Translated forms, documents, signage and client informing materials are provided.

ADAPTATION OF SERVICES TO IMPROVE CULTURAL COMPETENCE

The Role of Clients Driven/Operated Recovery and Wellness Programs

A valuable part of the SCDMHS services are client driven/operated recovery and wellness programs. Clients working in and attending these programs are able to reach out to others who both share their lived experience and often a common cultural/ethnic/racial heritage; they can also model progress toward recovery in the local communities. The client driven/operated programs range from client-operated clubhouses, warm line services, program advisory groups, Elder Multicultural Access and Support Services, client peer support programs, Roadmap to Recovery, Peer and Family Engagement Project, and Family Youth Roundtable.

Current Service Accommodations for Individual Preference

To help accommodate racial, ethnic and cultural preferences, some of the above programs have been adapted to further address the need for cultural/ethnic/racial/ linguistic service diversity:

- The Language Line provides interpreter services for all programs
- The Warm Line and the Adult Peer Support Line have Spanish speaking staff.
- Program Advisory Groups in the South Region (an area with a high Spanish speaking population) are conducted in English and Spanish.
- Roadmap to Recovery groups are facilitated in languages that reflect the population it serves and clients are free to choose among groups.
- Clients are free to change providers to get a more comfortable racial/ethnic or cultural "fit."

Outreach Efforts to Engage Unserved/Underserved Populations

The SDCMHS realized that traditional efforts to engage unserved and underserved populations were inadequate. Through MHSA funding, outreach services were begun to try to inform diverse communities of the availability of mental health services which could meet their cultural and linguistic needs. Staff on specialized programs such as Breaking Down Barriers, the Union of Pan Asian Communities, Chaldean Middle Eastern Social Services, Survivors of Torture International, and clinics such as Douglas Young and the Heritage Clinic are participating in neighborhood festivals, information fairs, refugee assistance efforts, food distribution services, and substance abuse prevention efforts. Outreach efforts have been made to reach youth and high school students in new ways, through the Internet and at a Youth Summit.

Location of Mental Health Services in Non-Threatening, Non-Stigmatizing Locations

A major effort has been made to begin to bring services to people where they are. Through MHSA funding, the SDCMHS is working with the Council of Community Clinics to co-locate services and create partnerships with primary care services to bring services to ethnic groups who are more comfortable in getting services at the family doctor's office. The Children's System of Care is now providing mental health services at over 300 community schools. On another level, new programs such as the Integrated Health Care Project, the Physical Health Integration Project, and the East County Integrated Health Access Project are striving to coordinate care to address the physical health and mental health needs of clients.

CONCLUSION

The SDCMHS has been moving along the road toward achieving cultural competence for over a decade now. Significant progress has been made, especially under MHSA, to tailor programs to meet the cultural, ethnic, racial and linguistic needs of diverse communities. Efforts to reach out to, engage, and retain in services, the underserved and unserved are still not as successful as they need to be. The use of Evidence Based Practices and the development of best practices models are helping point development efforts toward greater effectiveness. Program staff, operating with an awareness of the link between meeting the cultural needs of clients and helping them move toward recovery, are being given a greater array of tools to foster their own cultural competence. Programs are being called upon to conduct a yearly self-assessment of their ability to meet the cultural needs of clients. The course of action chosen by the SDCMHS is broad-based and sound, but there is still much left to do to create true systemwide cultural competence.

Live Well, San Diego!

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY